Funding Effective Implementation of Evidence-Based Programs in Child Welfare

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Contents

I. Introduction

Child welfare leaders have enormous responsibilities for ensuring critical outcomes for children and families. They have to keep children safe, support families in staying together whenever possible and promote the mental health and well-being of children and youth who have often experienced significant trauma. With such high stakes, they want to know their approaches will work.

There is a growing body of research documenting which interventions are effective in improving parenting skills, addressing conflict and supporting emotional well-being. Child welfare leaders, like human-service leaders across disciplines, are increasingly focused on investing in and implementing evidence-based programs.

As child welfare jurisdictions replicate evidence-based programs, it is clear that replicating outcomes requires effective implementation, and that effective implementation requires adequate resourcing. This brief provides child welfare agency administrators and partnering agencies (providers, intermediaries, funders) with strategies and examples from jurisdictions that have successfully funded, implemented and sustained evidence-based programs within the child welfare context. Administrators from nine child welfare agencies were interviewed and shared background information on their efforts to fund and implement evidence-based programs. Based on these real-world experiences, this brief highlights the costs, funding streams, partnerships and allocation of resources that are unique to child welfare systems and necessary for effective implementation of evidence-based programs. Individual profiles of each of the jurisdictions interviewed are included in the Appendices.

JURISDICTIONS INTERVIEWED

- Allegheny County, Pennsylvania.
- Catawba County, North Carolina
- Colorado
- Connecticut
- New York City
- New Jersey
- North Carolina
- Ohio (Children's Trust Fund)
- Washington

II. What Are Evidence-Based Programs, and Why Focus on Funding Them?

Evidence-based programs have undergone rigorous testing and demonstrated their effectiveness. These programs, having established a strong level of evidence, are often "packaged" and made available for replication. Evidence-based programs typically require specialized training and the use of specific supervision and practice guidelines, materials, monitoring and data reporting.

Administrators often think of evidence-based programs as "plug and play" and are surprised by the level of preparation and resources needed to implement them in a way that achieves outcomes. However, research has shown that *how* evidence-based programs are implemented is critically important, and that replications that do not follow the intended design are less likely to achieve the outcomes realized in the original evaluations.[1]

Clearinghouses rank programs by their level of evidence. For example, Blueprints for Healthy Youth Development (Blueprints) is a registry of evidence-based programs that promote the health and well-being of children and teens. The Blueprints registry includes only programs that are supported by at least one high-quality randomized control trial or two high-quality quasi-experimental evaluations. The California Evidence-Based Clearinghouse for Child

[1] Dean L. Fixsen et al., *Implementation Research: A Synthesis of the Literature.* Tampa: University of South Florida, Louis de la Parte Florida Mental Health Institute, 2005.

Welfare (CEBC) identifies and disseminates information regarding child welfare–related evidence-based programs. CEBC uses a scale from 1 to 5 to rate the strength of a program's evidence. A rating of 1 represents a practice with the strongest research evidence, and a 5 represents a concerning practice that appears to pose substantial risk to children and families.[2].

To identify evidence-based programs for this brief, authors referenced the Blueprints and CEBC databases; selected programs were either listed in the Blueprints database or received a CEBC rating of 1 or 2. Replications of programs with a rigorous level of evidence are more likely to achieve results. However, these programs also come with unique resource considerations and, in many cases, a higher per-child and -family cost than homegrown interventions. The trade-off is the increased assurance that evidence-based programs will achieve results and that, in the long term, their higher costs should be offset by the cost savings of more successful children and families.

What are evidence-based practices and policies?

While evidence-based programs are the primary focus of this brief, evidence can also be used to inform a child welfare agency's practice and policymaking decisions. An **evidence-based practice is an approach to prevention or intervention with families that is validated through controlled studies.** Evidence-based practices are distinguished from evidence-based programs in that they are generally broader approaches, rather than packaged interventions with specific training and fidelity-monitoring guidelines. For example, in the child welfare arena, providing guardianship assistance is a practice with a strong base of evidence that it increases permanency. **Evidence-based policies are policies, based on well-established research, that promote the use of or allocate resources toward evidence-based programs or practices.** For example, provisions of the Fostering Connections to Success and Increasing Adoptions Act (2008), which changed federal policy to allow IV-E support for subsidized guardianships, could be considered evidence-based policy.

III. What Kinds of Evidence-Based Programs Are Most Relevant to the Child Welfare Field?

As a first step, child welfare agency administrators and agency partners need to determine which evidence-based program(s) to use. A selected program must demonstrate that it can achieve the specific results needed and that it is effective with the population to be served. In service areas where there is substantial evidence for program models, evidence-based programs should be considered. In areas where there is less evidence, a jurisdiction can look to evidence-informed or promising practices to bolster their services and supports.

In the child welfare field, research has documented effective programs in several categories of services, including the following:

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[2] "Rating Scale." California Evidence-Based Clearinghouse for Child Welfare. Retrieved August 2017. http://www.cebc4cw.org/ratings/

- Parent education and child abuse prevention services (such as home visiting, parent training and engagement programs, prevention programs for at-risk families, early intervention with families reported to child welfare agencies)
- Behavioral management programs (such as intensive family therapy and case management, disruptive behavior treatment)
- Mental health services (such as individual and family models that address trauma, depression, anxiety, etc.)
- Domestic violence programs
- Substance abuse programs
- Therapeutic foster care and post-permanency support programs

In interviews, administrators reported using programs in the parent education and child abuse prevention category most frequently, followed by mental health, behavioral management, and substance abuse programs. There are only a handful of evidence-based therapeutic foster care and post-permanency programs, so it is not surprising that administrators reported using programs in this category least frequently.

IV. Understanding the Costs of Evidence-Based Programs

This brief uses an implementation science framework to consider the costs of evidence-based programs within the context of effective implementation. Implementation science looks at how systems and organizations can effectively adopt and integrate evidence-based practices, interventions and policies. Using a "stage-based implementation" framework, implementation science emphasizes that implementation is a process that occurs over time, and that each stage requires thoughtful efforts to ensure effective implementation and, in the case of child welfare programs, improved outcomes for children and families.

This framework can help administrators to consider costs at different stages of implementation. Four stages of implementation, each with unique resources considerations, are identified in the chart below. These stages are adapted from the National Implementation Research Network (NIRN) stages of implementation framework. Many additional resources on implementation are available on the NIRN website at http://nirn.fpg.unc.edu/.

TABLE 1: KEY COSTS ASSOCIATED WITH IMPLEMENTING EVIDENCE-BASED PROGRAMS

Stage	Definition	Key Costs/Resources to Consider During this Stage
Exploration	Evidence-based programs are identified based on assessment of the potential match between community needs, evidence-based program needs, and available resources.	• Data analysis to identify specific outcomes to be achieved and the target population • Staff time to analyze data and review current practices and programs for effectiveness • Staff time to research and select evidence-based programs that match desired outcomes and population to be served • Staff/leadership/partner time to discuss options, gain buy-in, and make decision

Installation	Resources and infrastructure are developed to prepare for implementation.	• Purchase of program materials (e.g., curricula) • Staff time for the development and administration of a Request for Proposal or contract amendment process for contracted services • Staff time to establish structures, processes and work supports within the agency to facilitate effective implementation • Purchase of initial training for staff, as well as staff time to attend training • Purchase and/or establishment of performance assessment tools • Development or adaptation of data systems • Procurement of necessary materials, equipment and space
Initial Implementation	Practitioners and staff integrate and refine new knowledge, skill, practices and procedures into daily work.	• Staffing and implementation costs • Data collection and analysis • Staff time to supervise initial implementation, troubleshoot challenges, and continue to align agency structures, processes and practices to the new program. • Purchase of and/or staff time for fidelity monitoring • Purchase of and/or staff time for technical assistance and coaching as new program is adopted
Full Implementation	Practitioners and staff routinely provide high-quality services, and new program becomes the way the organization carries out its work.	• Ongoing staffing and implementation costs • Ongoing training due to staff turnover • Ongoing data collection and analysis • Ongoing fidelity monitoring and quality improvement processes

V. The Funding and Policy Context for Evidence-Based Programs

It is important to understand that evidence-based programs are resourced and delivered within specific child welfare funding and policy contexts. Child welfare services are supported by a variety of federal, state and local funding streams, and the mix of funding streams varies greatly by state and local jurisdictions.

Five major **federal** funding streams support child welfare services. Two of these funding streams are dedicated child welfare streams administered by child welfare agencies: (1) Title IV-E, the largest federal funding stream supporting child welfare, which provides funding for core services including foster care, case management, and permanency subsidies; and (2) Title IV-B, which provides funding for prevention, family preservation, reunification and permanency supports. The three other major funding streams supporting child welfare services are the Temporary Assistance for Needy Families (TANF) program, the Social Services Block Grant (SSBG), and Medicaid; these more general social service and health streams are commonly used by states to help support child welfare services. In addition, there is one small federal funding stream dedicated to child abuse prevention, the

Community-Based Child Abuse Prevention (CBCAP) block grant. Governors designate the lead agencies for CBCAP funds, which are often administered from Children's Trust Funds or other specialized offices within states. (See Table 2 for more details on federal programs.)

Each of these federal streams presents challenges for evidence-based programs. Title IV-E, the bulk of federal child welfare funding, is very restricted in its uses, focusing primarily on supporting out-of-home placement and case management. Furthermore, Title IV-E only reimburses states for services to income-eligible families, and income eligibility standards have not been adjusted in more than 20 years. As a result, over time, fewer and fewer families qualify for Title IV-E reimbursement, and states see a corresponding decline in federal funding. TANF and SSBG funds are more flexible but also more limited in amounts—in addition, they face many demands beyond child welfare for use at the state level. Title IV-B and Medicaid are the federal funding streams that most often fund evidence-based programs, yet neither comes without its own set of complications. Title IV-B is a very small funding stream compared to the scope of prevention, reunification and other services needed within child welfare, and Medicaid supports only clinical evidence–based programs, such as Multisystemic Therapy or Functional Family Therapy.

There have been recent attempts to change the current federal financing structure — by moving financial incentive away from out-of-home care and toward evidence-based prevention programs — but those efforts have been unsuccessful thus far.[3] Despite federal funding restrictions, the Children's Bureau has increased its focus on well-being and has continued to prioritize funding evidence-based programs in its discretionary grants. In the current federal policy climate, there is a strong likelihood that additional budget cuts will be coupled with an increasing focus on funding evidence-based programs. This will result in a growing pressure on states to ensure that their child welfare services achieve results, despite a continued context of limited federal resources.

Not surprisingly, as federal IV-E eligibility requirements have become outdated and other federal funding streams have remained flat, the **state** share of funding for child welfare has grown in an attempt to meet the demand. Overall, almost half of state and local funds spent on child welfare in recent years have been used to finance out-of-home placement costs for children ineligible for federal Title IV-E reimbursement.[4] States and counties vary widely in the amount of state and local dollars they invest in community-based services that help prevent entry into foster care or ease the transition home. As the states' share of out-of-home placement costs grows, state leaders have seen that investing in effective community-based services that prevent costly out-of-home placements can save money and lead to better outcomes for families and children.

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[3] *When Child Welfare Works: A Proposal to Finance Best Practices.* Annie E. Casey Foundation 2013.
[4] *Child Welfare Financing SFY2014: A Survey of Federal, State and Local Expenditures*. Child Trends 2016.

TABLE 2: MAJOR FEDERAL FUNDING SOURCES SUPPORTING CHILD WELFARE SERVICES

Funding Source	Child Welfare Purpose	Opportunities to Fund Evidence-Based Programs	Child Welfare Expenditures for FY 2014 as reported by States[5] *(in billions)*
Title IV-E	Supports out-of-home placement and case management for eligible children, caseworker and resource family training, and adoption and guardianship payments	Can support evidence-based therapeutic foster care placements; can also support training for caseworkers on assessments and referrals to evidence-based programs. The Title IV-E Waiver Demonstration Program has given participating states more flexibility, allowing funds to be used to cover start-up and implementation costs for evidence-based programs.	$6.7
Title IV-B	Supports prevention, family preservation/reunification, workforce, and court improvement	Can support evidence-based family support and prevention programs	$0.6
Medicaid	Supports direct health-care services and specific services related to child welfare, including targeted case management, rehabilitative services and therapeutic foster care	Can reimburse for therapeutic evidence-based programs, such as those that address trauma and other mental and behavioral issues	$0.8
Temporary Assistance for Needy Families (TANF)	Supports child welfare services that meet at least one of the main purposes of the program, including helping children to be cared for in their own homes or with relatives	Can support evidence-based programs such as home-visiting, parent training, and other early interventions for at-risk families	$2.8

[5] Based on an analysis of 48 states. For full report, see *Child Welfare Financing SFY2014: A Survey of Federal, State and Local Expenditures*. Child Trends 2016. https://childtrends-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2016/10/2016-53ChildWelfareFinancingSFY2014-1.pdf.

Social Services Block Grant (SSBG)	Supports child welfare services including prevention, child protection, and reunification	Flexible funding source; can support a range of evidence-based prevention and reunification programs, as well as substance abuse and domestic violence programs	$1.3
Community-Based Child Abuse Prevention (CBCAP) grants	Supports community-based child abuse and neglect prevention efforts	Can support child abuse prevention programs	$0.09

VI. Strategies for Funding and Sustaining Evidence-Based Programs

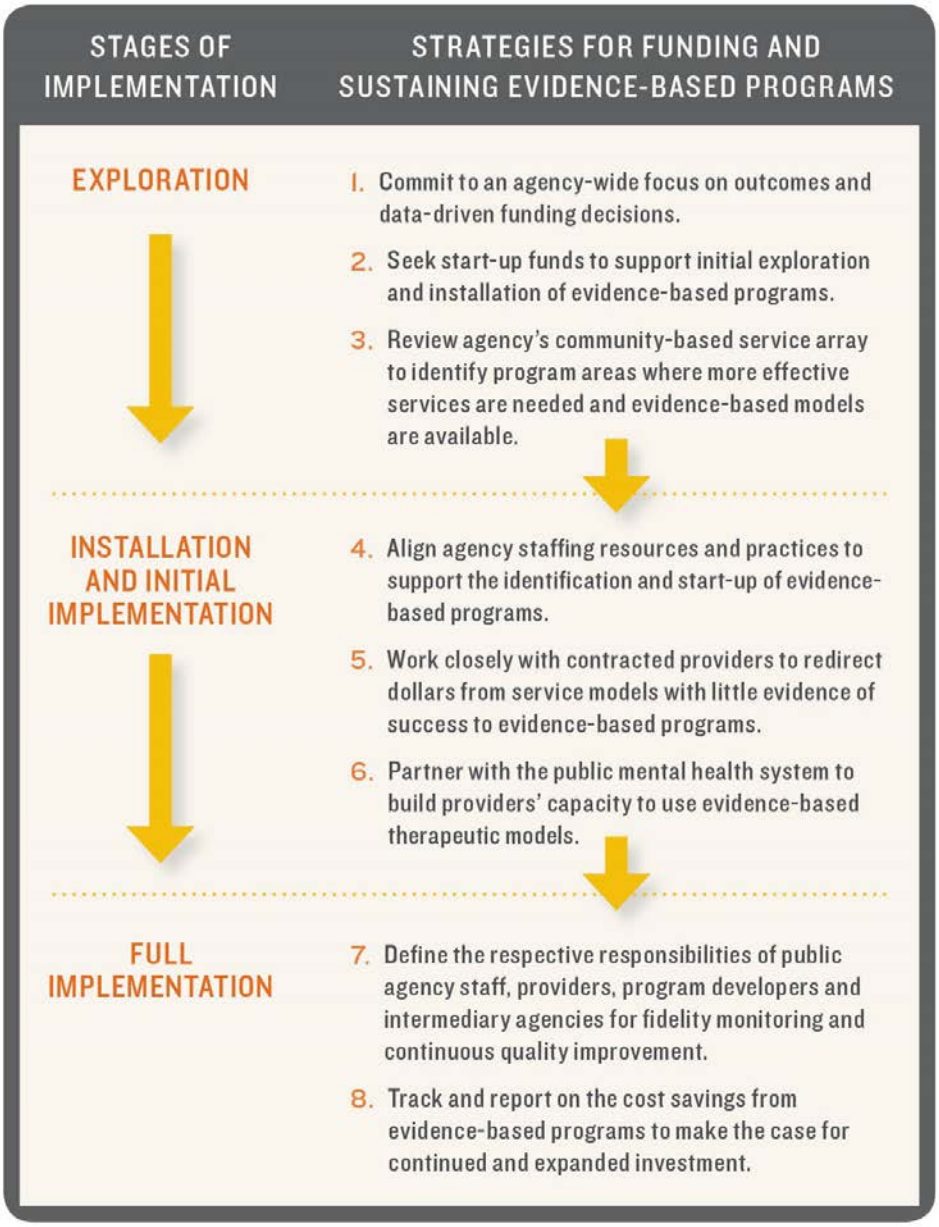
The child welfare leaders interviewed for this brief have worked for many years to improve the effectiveness of child welfare services and support evidence-based programs. Overall, they reported that the programs were primarily funded through existing budget allocations for community-based contracts and fee-for-service therapeutic services. The funding streams supporting these services were state dollars (and county or city dollars, in local jurisdictions), federal Title IV-B and Medicaid. Two of the states also used federal CBCAP grants, and two states used Title IV-E waivers.

Reflecting on their experiences in funding and sustaining evidence-based programs, the child welfare leaders identified pitfalls they have learned to avoid (see below) — and more importantly, they shared a variety of successful strategies they have employed.

Common Pitfalls to Avoid in Funding and Sustaining Evidence-Based Programs

- There are insufficient up-front investments made to ensure that the right evidence-based program is selected to match the specific intended outcomes, the population being served, and the available resources.
- Evidence-based programs are contracted for without dedicating adequate resources to integrating the practice within the agency's service array (educating workers, establishing referral processes, aligning policy).
- The reimbursement rates in contracts and/or through Medicaid are not sufficient to pay for client engagement, delivery of the service and data collection and fidelity-monitoring tasks.
- Inadequate attention to referral sources and processes and/or a poor match of the program to client needs and capacities lead to poor take-up of the program.
- High staff turnover leads to interruptions in service availability and unanticipated expenses for training new staff.
- Funding for monitoring and quality improvement is cut in tight fiscal times, and ongoing accountability for fidelity and results is lost.

This section highlights eight strategies that will help administrators overcome challenges and successfully fund and sustain evidence-based programs in child welfare agencies. The sequence of strategies aligns with the implementation science framework (see visual below). Strategies 1–3 establish the foundation for identifying and funding evidence-based programs (**Exploration**). Strategies 4–6 are critical in both preparing for effective implementation (**Installation)**, and supporting program start-up (Initial **Implementation**). Strategies 7–8 focus on ensuring long-term success of and support for the programs (**Full Implementation**).



1. COMMIT TO AN AGENCY-WIDE FOCUS ON OUTCOMES AND DATA-DRIVEN FUNDING DECISIONS.

Child welfare agency leaders' commitment to implementing evidence-based programs was often part of a larger strategic shift within the agency to focus on achieving outcomes. In some cases, the impetus for this focus came from a governor or the legislature, while in others it came primarily from the agency's leadership. The commitment to accountability for outcomes creates an environment of investing in results rather than services, and lays the foundation for the successful, data-driven resourcing of evidence-based programs.

2. SEEK START-UP FUNDS TO SUPPORT INITIAL EXPLORATION AND INSTALLATION OF EVIDENCE-BASED PROGRAMS.

For most of the child welfare agencies, an infusion of resources from private foundation funds, federal discretionary grants, or IV-E waivers provided important support for their exploration and installation work. The short-term funding streams helped them:

1) prioritize the identification and installation of evidence-based programs by creating external accountability;

2) dedicate the necessary staff time and resources to assessing needs, reviewing the potential fit of various models, engaging stakeholders in the decision-making process and designing implementation supports; and

3) access technical expertise, including assistance with implementation science, various evidence-based program models and data analysis and evaluation.

TABLE 3: SHORT-TERM FUNDING STREAMS SUPPORTING EXPLORATION AND INSTALLATION

Funding Stream	Supports	Jurisdictions Using Funding Source
IV-E waiver	• Identification of evidence-based programs • Data analysis and evaluation • Initial training for and implementation of evidence-based programs	• Allegheny County, PA • Colorado
Private foundation funds	• Implementation technical assistance • Data capacity building • Public agency staff time for exploration and installation • Initial training on evidence-based programs	• Allegheny County, PA • Catawba County, NC • New York City, NY • New Jersey • North Carolina

Federal discretionary grants • Substance Abuse and Mental Health Services Agency (SAMHSA) Child Traumatic Stress network grant • Children's Bureau Integrating Trauma-informed Practice in Child Protective Service Delivery grant • Children's Bureau National Quality Improvement Center for Adoption and Guardianship project	• Identification of evidence-based programs • Initial training on and implementation of evidence-based programs • Training of agency staff in trauma-informed approaches and screening and referral processes • Data collection and model evaluation	• Colorado • North Carolina • Catawba County, NC

3. REVIEW AGENCY'S COMMUNITY-BASED SERVICE ARRAY TO IDENTIFY PROGRAM AREAS WHERE MORE EFFECTIVE SERVICES ARE NEEDED AND EVIDENCE-BASED MODELS ARE AVAILABLE.

Across the jurisdictions, leaders reported that they primarily used existing budget dollars to support evidence-based programs. Agencies reviewed community-based services to determine areas where programs were not achieving the desired outcomes. Once they identified these areas for improvement, agency staff researched evidence-based models that could meet client needs and gathered input from community-based providers on their capacity to implement evidence-based models. Agencies most typically identified evidence-based models for providing community- and home-based family preservation services and therapeutic services.

4. ALIGN AGENCY STAFFING RESOURCES AND PRACTICES TO SUPPORT THE IDENTIFICATION AND START-UP OF EVIDENCE-BASED PROGRAMS.

The bulk of resources needed in the exploration and installation phases are the agency staffing to lead, coordinate and participate in the process of identifying appropriate models, as well as to make sure that new models align with agency policy, practice, and data systems. Child welfare leaders reported taking the following steps to provide adequate staffing for the effective implementation of evidence-based programs:

- Designate staff leads at the state agency and regional or county offices who are responsible for coordinating and overseeing the identification and installation of evidence-based programs, and who regularly communicate with each other about progress.

- Structure planning processes and information-sharing events to engage the provider community, and educate them about models once selected.
- Establish leadership teams from across agency departments that meet regularly to address contracting, training, policy and data needs during the installation phase.
- Create implementation teams that bring together child welfare agency program and data staff, providers, and other key partners to identify appropriate programs, prepare for program installation (and eventually monitor ongoing implementation), and address challenges that might arise.
- Integrate training on the screening, assessment and referral processes for evidence-based programs into new and ongoing worker training, supported with federal IV-E dollars.
- Develop supports for workers (e.g., desk guides with descriptions of evidence-based models being implemented and referral criteria, web-based decision-making tools connected to assessment data that identify the appropriate models for referral).

5. WORK CLOSELY WITH CONTRACTED PROVIDERS TO REDIRECT RESOURCES FROM MODELS WITH LITTLE EVIDENCE OF SUCCESS TO EVIDENCE-BASED PROGRAMS.

Agency staff worked closely with providers to identify effective evidence-based programs; the selected models were added through contract amendments or integrated into rebid requests. Contract changes often require a redirection of resources, with the potential for increased contract amounts. Multiple jurisdictions reported that they revised payment rates for providers based on a review of the staffing requirements for program implementation, which included not only the direct service delivery but also fidelity monitoring and continuous quality improvement activities. Two jurisdictions (New York City and Washington) noted that they ultimately needed to integrate payment for additional hours for general casework into their rates. They found that the evidence-based models were more clinical in nature than previous family preservation and prevention services, and that service providers engaging with families needed to be able to devote time to addressing practical needs, such as housing and employment, that extended beyond the program models.

State leaders anticipated that increased rates for evidence-based programs could mean fewer families would be served than through the previous, less expensive models. In the course of implementation, however, they found that the number of families served did not decrease. The increased rates were offset by the clearly defined duration of evidence-based programs, which often ends up being shorter than the length of service for less-structured family support and parenting programs.

6. PARTNER WITH THE PUBLIC MENTAL HEALTH SYSTEM TO BUILD PROVIDERS' CAPACITY TO USE EVIDENCE-BASED THERAPEUTIC MODELS.

Jurisdictions also partnered with the public mental health system to implement therapeutic models, such as the Trauma-Based Cognitive Behavioral Therapy or Child–Parent Psychotherapy programs. Like child welfare leaders, public mental health system leaders are interested in building clinicians' capacity to deliver evidence-based programs. The extent to which the mental health and child welfare systems partner to deliver behavioral health services to children in care varies significantly across states. The agencies interviewed offered multiple examples of child welfare leaders partnering with mental health system leaders and building on existing public mental health infrastructure. For example, in Catawba County, county mental health workers are trained in the Parent–Child Interaction Therapy model, which they can deliver to child welfare clients. Colorado's Title IV-E waiver included support to create a partnership with Community Mental Health Centers to deliver evidence-based trauma treatment, and Medicaid funds support ongoing delivery.

7. DEFINE THE RESPECTIVE RESPONSIBILITIES OF PUBLIC AGENCY STAFF, PROVIDERS, PROGRAM DEVELOPERS AND INTERMEDIARY AGENCIES FOR FIDELITY MONITORING AND CONTINUOUS QUALITY IMPROVEMENT.

An important step in ensuring the sustainability of evidence-based programs is to provide supports for ongoing data collection and review and continuous quality improvement. In most jurisdictions, the public agency shares responsibility for continuous quality improvement with providers and program developers. Under their contractual terms, providers are responsible for fidelity monitoring and reporting implementation and outcomes data to the child welfare agency. Model developers may offer ongoing coaching and support for fidelity monitoring, and can help providers and public agency staff address challenges such as maintaining fidelity to the model within the confines of public agency policies and requirements. Implementation teams and other planning structures developed for installation require less intensive work as the installation and initial implementation phases shifts into full implementation, but they continue to meet to review real-time implementation data and troubleshoot challenges that arise. One state (North Carolina) reported using state dollars in combination with private funds from The Duke Endowment, a North Carolina-based private foundation, to fund an intermediary agency for implementation support. In their county-administered system, leaders in North Carolina viewed the implementation support as essential to their success.

8. TRACK AND REPORT ON THE COST SAVINGS FROM EVIDENCE-BASED PROGRAMS TO MAKE THE CASE FOR CONTINUED AND EXPANDED INVESTMENT.

Evidence-based prevention and family preservation programs can help reduce the number of children who enter or re-enter care. Likewise, evidence-based therapeutic programs can help reduce entries to costly institutional placements. While most leaders interviewed did not have formal mechanisms in place for calculating cost savings and reinvesting them in evidence-based programs, they noted that reductions in out-of-home placements led to savings that relieved pressure on their budgets and made it easier to make the political case for continued investment. For example, Connecticut shifted funding to enhance their community-based service array through evidence-based and promising models. Over five fiscal years, the state spent $80 million less on congregate care and reinvested much of those dollars into more effective services.

VII. Conclusion

Child welfare leaders interviewed for this brief demonstrate that it is possible to reallocate child welfare resources toward evidence-based programs — and to transform key service areas in the process. This shift requires strong leadership and a commitment to being accountable for improving outcomes for the children and families served. Child welfare agencies must also make a thoughtful and sustained effort to align existing agency staffing and resources in support of successful implementation. Another critical factor is their ability to work productively with contracted community-based providers to identify service areas in which evidence-based models will improve outcomes, and to redirect community-based contract dollars accordingly.

The benefits of intentional efforts to invest in and implement evidence-based programs can extend well beyond individual program outcomes. As child welfare agency leaders and staff focus on implementation, they learn the importance of delivering services with fidelity to a model and develop new systems and processes for data collection, contract monitoring and continuous quality improvement. These capacities can contribute to better outcomes across all services, ultimately leading to increased safety and well-being for the children and families they serve.

CITATIONS

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Appendices Contents

Appendix A. Evidence-Based Programs by Jurisdiction

Evidence-Based Program	Jurisdiction								
	Allegheny County, PA	Catawba County, N.C.	Colorado	Connecticut	New Jersey	New York City	North Carolina	Ohio	Washington State
Adolescent Community Reinforcement Approach/Assertive Continuing Care (ACRA/ACC)				X					
Attachment and Biobehavioral Catch-up (ABC)							X		
Brief Strategic Family Therapy (BSFT)						X			
Child First				X			X		
Child–Parent Psychotherapy (CPP)			X			X	X		
Functional Family Therapy (FFT)			X	X	X	X			X
Healthy Families					X				
Homebuilders	X						X		X
Home Instruction for Parents of Preschool Youngsters (HIPPY)					X				
Incredible Years							X	X	X
Multidimensional Family Therapy (MDFT)				X					
Multisystemic Therapy (MST)	X		X	X	X				
Multisystemic Therapy for Child Abuse and Neglect						X			
Multisystemic Therapy for Problem Sexual Behavior (MST-PSB)				X					
Nurse Family Partnership					X				
Parent–Child Interaction Therapy (PCIT)	X	X	X				X		X
Parenting with Love and Limits (PLL)			X						
SafeCare						X	X		X
Strengthening Families		X					X	X	
Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)			X	X	X		X		
Triple P				X			X	X	X

Note: The programs listed are the programs that administrators cited as being implemented at the time of interviews, and are included in the Blueprints for Healthy Youth Development registry or are rated a 1 or 2 in the California Evidence-Based Clearinghouse for Child Welfare. This list does not necessarily include every evidence-based program these jurisdictions are funding.

Appendix B. Child Welfare Jurisdiction Profiles

B-1. Allegheny County, Pennsylvania.

BACKGROUND/CONTEXT

The Allegheny Department of Human Services (DHS) is the umbrella human service agency for Allegheny County, Pennsylvania. DHS administers a wide range of services related to child protection, prevention, older adults, mental health, substance use, homelessness, supported housing and disabilities. The Pennsylvania State Department of Human Services, Office of Children, Youth and Families uses a needs-based planning and budget process to determine state funding allocation for county human service agencies. Counties must use data to document their needs and develop plans for addressing those needs.

In addition to the usual mix of state, county and federal child welfare funding, Allegheny DHS receives local funding from the Human Services Integration Fund (HSIF). HSIF was formed in 1997 when a group of local foundations came together to provide flexible funding to DHS to support innovative approaches that were not possible with public sector dollars. Since HSIF's inception, member foundations have contributed more than $12 million. Among other initiatives, the fund supported the creation of a data warehouse that has greatly expanded DHS's capacity for program monitoring and analysis. DHS regularly evaluates all of its programs and services, and makes the reports publicly available.

Allegheny DHS has a history of implementing evidence-informed and evidence-based programs. In 2012, Allegheny was one of six counties in Pennsylvania to participate in a federal Child Welfare Waiver Demonstration Project, in which participating counties committed to the expanded use of evidence-based practices driven by local needs.

EVIDENCE-BASED PROGRAMS

Program Name	Demonstrated Outcome Area					Implementation Funding Source								
	Parenting Ed & Prevention	Behavioral Management	Mental Health	Substance Use	Therapeutic Foster care & Perm Supports	State	City/ County	IV-E*	IV-B	TANF	Medicaid	CBCAP	Federal Discretionary	Private
Homebuilders	X				X	X	X	X						
Multisystemic Therapy (MST)	X	X	X	X		X					X			
Parent–Child Interaction Therapy (PCIT)	X	X	X			X	X	X			X			

Note: Allegheny DHS delivers additional models that do not meet the definition of evidence-based programs used in this brief, but that staff identified as evidence-informed or promising. These programs include Parents as Teachers and High Fidelity Wraparound.
** These programs are funded through a Title IV-E waiver.*

FINANCING EVIDENCE-BASED PROGRAMS

Key Lessons Learned

- Child welfare funding is limited, so it is important to carefully select evidence-based programs by considering which model is the best match for the identified needs. Also, think about whether the program will achieve significant outcomes for enough families and children to justify the total cost of implementation. The program must be accessible, inviting and fully engaging to those it serves.
- Investments to support accountability and transparency are worthwhile. An outcome-based data system can transform an agency's orientation toward ensuring that results are replicated, not just programs. Sharing publicly what services children and families are getting, what outcomes are being achieved and what gaps and challenges still remain can engage local community stakeholders, such as residents, businesses, civic organizations and academic institutions.

Resources Supporting Exploration and Installation

- The federal Child Welfare Waiver Demonstration Project prompted Allegheny DHS to look for evidence-based programs, and Homebuilders and Parent–Child Interaction Therapy (PCIT) were identified as good matches. The waiver enabled DHS to pay for training and many start-up costs with federal Title IV-E funds.
- During the installation phase, DHS built their internal capacity for monitoring and fidelity by training key agency staff, such as contract monitors, in the evidence-based programs. The agency also contracted with Homebuilders to develop tailored data collection tools and integrate the data into the DHS systems.
- For Homebuilders, DHS issued a request for proposal to potential providers and received 16 proposals. The two selected providers demonstrated in their proposals that they had the capacity to implement at a high level, serve the intended families and be accountable for results.
- The PCIT program was integrated into existing Family Support Centers throughout Allegheny County. The neighborhood-based centers, a hub for many services, had already established trust with the families in their communities. HSIF provided flexible funding for the setup of dedicated rooms for PCIT.

Resources Supporting Implementation and Sustainability

- Allegheny County's implementation of PCIT and Homebuilders continues to receive IV-E support through the federal Child Welfare Waiver Demonstration Project, along with some state, county and Medicaid funding. When the waiver expires in 1 – 2 years, there are plans to use state, county and Medicaid dollars to support the programs in full, as long as they continue to demonstrate results.
- DHS reviews data on costs, utilization and outcomes on an ongoing basis to determine whether the implementation of evidence-based programs is effective. In the case of MST, high costs, inappropriate referrals and low utilization rates resulted in the agency's decision to phase out the program.
- Contracted providers continue to deliver programs, while monitoring, data collection and reporting remain internal to the agency. The ongoing partnership with HSIF ensures that DHS has the overall capacity to track and report on outcomes.

B-2. Catawba County, North Carolina

BACKGROUND/CONTEXT

Catawba County Social Services is the county-administered agency responsible for administering child welfare, Medicaid, disability and TANF services in Catawba County, North Carolina. In 2007, Catawba County and The Duke Endowment, a North Carolina-based private foundation, launched the Child Wellbeing Project. The project invests in post-foster care services to improve long-term outcomes of children and youth and ultimately create cost savings. Although Catawba County had a long record of innovation and integration of best practices throughout its continuum of child welfare services, the county did not provide any post-foster care services to children, youth or families once they had achieved permanence or aged out of the system.

From its inception, the Child Wellbeing Project focused on delivering evidence-based and needs assessment-informed services for post-foster care children and families. In addition to these programs, Catawba County Social Services developed an enhanced case-management model called Success Coach, which is currently undergoing a randomized control trial to demonstrate its effectiveness.

EVIDENCE-BASED PROGRAMS

Program Name	Demonstrated Outcome Area					Implementation Funding Source								
	Parenting Ed & Prevention	Behavioral Management	Mental Health	Substance Use	Therapeutic Foster Care & Perm Supports	State	City/ County	IV-E	IV-B	TANF	Medicaid	CBCAP	Federal Discretionary	Private
Parent–Child Interaction Therapy (PCIT)	X	X	X				X				X			
Strengthening Families	X	X		X			X				X			
Note: Catawba County delivers additional models that do not meet the definition of evidence-based programs used in this brief, but that staff identified as evidence-based or promising, such as Success Coach.														

FINANCING EVIDENCE-BASED PROGRAMS

Key Lessons Learned

- Private foundations can be critical partners during the exploration and installation stages. It requires time and resources to identify the right evidence-based programs to meet the specific needs of families and children. Resourcing program start-up through federal and state child

welfare funding streams is often challenging, whereas private funders see supporting exploration and installation as an effective, time-limited approach to partnering with a public agency to improve outcomes.

- Most evidence-based programs are targeted and clinical in nature, and models that serve child welfare needs can be difficult to find, even with adequate resources. Make sure that the programs selected are well matched to the needs and capacities of the families and children to be served.
- Learning how to effectively implement and resource evidence-based programs can improve how an agency approaches all of its work. Implementation science offers a framework for understanding how to better deliver core services with fidelity to a model, practice or approach. Further, implementation of evidence-based programs requires creating systems for monitoring, collecting data and reporting on outcomes. These accountability systems are needed across all child welfare services, regardless of their level of evidence.

Resources Supporting Exploration and Installation

- At the outset of the Child Wellbeing Project, The Duke Endowment funded a comprehensive needs assessment that included interviews with families and staff about post-foster care needs. Literature reviews were then conducted on the six identified areas of need.
- The Duke Endowment supported technical assistance from the National Implementation Resource Network (NIRN). NIRN helped Catawba County create six implementation teams that aligned with the six areas of need. Although the teams varied in composition, all teams included social workers, supervisors and community stakeholders. The teams reviewed the needs assessment and literature reviews, conducted their own research and made recommendations on what evidence-based programs would best meet the needs of families and children. Parent-Child Interaction Therapy (PCIT) and Strengthening Families were selected.
- The Duke Endowment provided Catawba County Social Services with funding to create 5–6 new “capacity” positions, i.e., full-time frontline staff positions. This reduced caseloads across all social workers, which freed up their time to be full team participants during implementation. The expertise of the frontline staff was invaluable during the needs assessment, selection and start-up of the evidence-based programs.
- The Child Wellbeing Project supported the initial setup and training required for the selected evidence-based programs. For example, The Duke Endowment funded the setup of PCIT rooms and the training of clinicians to deliver the services, as well as supervisor training on how to coach staff and ensure fidelity in implementation.

Resources Supporting Implementation and Sustainability

- County and Medicaid funding support the ongoing implementation of the evidence-based programs. For example, county mental health clinicians, now trained in PCIT, use the model with their clients. Fidelity monitoring and data collection are integrated into the county's existing structures.
- While the expanded capacity positions funded by The Duke Endowment were regular, full-time positions, they were not considered to be long term. As the evidence-based programs moved beyond the intense exploration and installation phases, the social workers did not need to devote as much time to the implementation teams and were able to resume normal caseloads. Once installation was complete, day-to-day functions could be managed by fewer staff, and the capacity positions were phased out primarily through natural attrition.
- The Child Wellbeing Project resulted in Catawba County Social Services developing an enhanced case-management model called Success Coach. Success Coach is a voluntary, in-home service that acts as a hub for families to access other post-care services. In addition to assessing needs and setting goals, Success Coach helps determine what services are most appropriate for the family, including whether an evidence-based program is a good fit. With Catawba's continued commitment to implementing evidence-based programs, the Success Coach model is currently undergoing a randomized control trial.

B-3. Colorado

BACKGROUND/CONTEXT

The Colorado Department of Human Services (DHS), Office of Children, Youth and Families, Division of Child Welfare is responsible for state supervision of child welfare in the county-administered state. Colorado has focused on increasing investment in evidence-based programs in two main areas: 1) family preservation services and 2) therapeutic models to address trauma.

Since 1994, Colorado has invested in family preservation services, considered to be "core services, via the Core Services Program." A total of $54.5 million is allocated annually to core services ($51.5 million in state funds and $3 million in federal Title IV-B funds). Counties have significant latitude in their use of Core Service Program funding; they may invest in services that strengthen families, protect children, prevent out-of-home placement and/or facilitate reunification and permanency. Since 2003 – 2004, the Colorado legislature's human services appropriation bill has included language that requires the Core Services Program to invest in evidence-based adolescent programs. These programs, currently funded at $4 million across the state, are primarily supporting Multisystemic Therapy (MST), Functional Family Therapy (FFT), and Parenting with Love and Limits. The Core Services Program can also provide services to families who do not have an open child welfare case by offering prevention/intervention services.

In addition, Colorado received a IV-E Waiver in 2012. The waiver focuses on five interventions, including trauma-informed assessment and trauma-focused treatment. Counties apply to take part in the waiver annually and can choose which of the five interventions to implement. Counties opting to implement trauma-informed assessment and trauma-focused treatment interventions can select from a short list of evidence-based models, including Child-Parent Psychotherapy, Trauma-Focused Cognitive Behavioral Therapy and Parent-Child Interaction Therapy. In 2016 – 2017, 21 out of 64 counties implemented trauma-informed assessment and treatment under the waiver.

EVIDENCE-BASED PROGRAMS

Program Name	**Demonstrated Outcome Area**					**Implementation Funding Source**								
	Parenting Ed & Prevention	Behavioral Management	Mental Health	Substance Use	Therapeutic Foster Care & Perm Supports	State	City/ County	IV-E*	IV-B	TANF	Medicaid	CBCAP	Federal Discretionary	Private
Child–Parent Psychotherapy (CPP)			X	X		X		X			X			
Functional Family Therapy (FFT)		X	X	X		X			X					

Multisystemic Therapy (MST)	X	X	X	X		X			X		X			
Parent–Child Interaction Therapy (PCIT)	X	X	X			X		X			X			
Parenting with Love and Limits (PLL)		X	X			X			X					
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)		X	X			X		X			X			
Note: Colorado delivers additional models that do not meet the definition of evidence-based programs used in this brief, but that staff identified as evidence-informed or promising. These programs include Alternatives for Families: Cognitive Behavioral Therapy and Adolescent Dialectical Behavior Therapy. ** These programs are funded through a IV-E waiver.*														

FINANCING EVIDENCE-BASED PROGRAMS

Key Lessons Learned

- Rural communities face unique challenges in implementing evidence-based programs:

    1. Often there are very few or no providers or clinicians available to deliver services in rural settings.

    2. The significant up-front investments and sustained fidelity required of many evidence-based programs may be too costly for a rural community with only a small number of clients needing the service.

    3. Ensuring program utilization is challenging when families must travel long distances to access the services.

To help ensure the successful implementation and sustainability of evidence-based programs, states should consider and devise investment and administration strategies in partnership with rural areas that specifically address these concerns. Approaches could include regional partnerships in rural areas; building on existing infrastructure in other systems, such as mental health and education; and identifying evidence-based programs that are a good fit for implementation in rural areas.

Resources Supporting Exploration and Installation

- For the evidence-based programs within core services, individual counties have the flexibility to assess their young people's needs and identify appropriate models to serve them.

- The waiver built on an existing effort in Colorado to develop a system of care for children with serious behavioral challenges. The effort, funded by a child traumatic stress network grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), was a partnership between the DHS Office of Behavioral Health and the Office of Children, Youth and Families to build capacity for trauma-informed assessment and treatment. The assessments and treatments identified through this work were incorporated into the waiver.
- Colorado has delivered trauma-informed treatment programs through community mental health centers (CMHCs). Some counties have funded positions (e.g., trauma treatment coordinators) dedicated to ensuring effective referrals, communication and coordination between child welfare staff and the CMHC staff responsible for trauma assessments and treatment. These positions are critical in the early implementation period as the two systems learn to work together.

Resources Supporting Implementation and Sustainability

- Funding for evidence-based adolescent services comes primarily from state legislature–appropriated dollars. This is part of a long-standing allocation to the Core Services Program, which is evaluated annually and has been found to be effective in keeping children in their home and out of foster care placements.
- Medicaid, IV-E waiver and state dollars support the trauma-informed evidence-based treatments. Many of these services are delivered within CMHCs, which receive infrastructure funding from the mental health system.
- An important goal of the IV-E waiver is to reduce spending on out-of-home and congregate care placements. Early implementation evaluation results found that participating counties saw a greater reduction in foster care placement days and congregate care days than nonparticipating counties. Overall, participating counties experienced a 16 percent reduction in foster care expenditures over the first two years of the waiver. DHS leadership plans to use state savings on out-of-home placements to sustain the interventions supported by the waiver.

B-4. Connecticut

BACKGROUND/CONTEXT

The Connecticut Department of Children and Families (DCF) is responsible for child protection, behavioral health, juvenile justice and prevention services. DCF has gradually increased its implementation of evidence-based programs over the past 15 years, a shift driven by the state's growing commitment to a Results-Based Accountability™ (RBA) approach.

The Connecticut General Assembly began studying whether they could adopt an RBA approach in 2004 and spent several years piloting approaches. In 2011, the legislature passed Public Act No. 11-109, which mandated the development of a Children's RBA Report Card. The newly appointed DCF commissioner fully embraced the RBA focus. The agency's program planning and evaluation processes fully integrated the RBA framework, and DCF invested in extensive staff training. In recent years, the increased focus on defining and measuring results has led to a dramatic increase in the number of evidence-based programs delivered.

EVIDENCE-BASED PROGRAMS

Program Name	Demonstrated Outcome Area					Implementation Funding Source								
	Parenting Ed & Prevention	Behavioral Management	Mental Health	Substance Use	Therapeutic Foster Care & Perm Supports	State	City/County	IV-E	IV-B	TANF	Medicaid	CBCAP	Federal Discretionary	Private
Adolescent Community Reinforcement Approach/ Assertive Continuing Care (ACRA/ACC)				X		X								
Child First			X			X								
Functional Family Therapy (FFT)		X	X	X		X					X			
Multidimensional Family Therapy (MDFT)		X	X	X		X					X			
Multisystemic Therapy (MST)	X	X	X	X		X								
Multisystemic Therapy for Problem Sexual Behavior (MST-PSB)	X	X				X								
Trauma-Focused Cognitive		X	X			X					X			

Behavioral Therapy (TF-CBT)														
Triple P	X	X	X			X								
Note: Connecticut delivers additional models that do not meet the definition of evidence-based programs used in this brief, but that staff identified as evidence-informed or promising. These programs include Bounce Back, Circle of Security Parenting, Child and Family Traumatic Stress Intervention, MST-BSF and MST-FIT, among others.														

FINANCING EVIDENCE-BASED PROGRAMS

Key Lessons Learned

- For evidence-based programs to be delivered successfully, a total commitment to resourcing all aspects of implementation is essential. This includes up-front investments in infrastructure to support data analyses, identification and tracking of outcomes, staff training and fidelity monitoring.
- Resources for evidence-based programs are typically identified through existing funds. Shift resources away from purchasing services and toward purchasing results.
- Conduct a “surgical review” to determine which programs are working and which are not, and why. If efforts to improve a service or a program are not effective, explore whether there are appropriate evidence-based models that will achieve the intended results.
- Providers are important partners throughout the process. They can help identify appropriate outcomes and potential evidence-based programs and think creatively about how to implement selected evidence-based programs, building off their existing expertise and infrastructure.

Resources Supporting Exploration and Installation

- With the state general assembly and DCF leadership fully committed to RBA, resources were invested in building a robust accountability system. DCF created mechanisms for reviewing the effectiveness of all agency programs. DCF worked with providers and model developers to define outcomes for each service type; using DCF data to track outcomes for the children and youth they served, providers assessed the effectiveness of existing interventions. If a service model was not producing the desired results, DCF engaged providers in a process to identify possible evidence-based programs.
- After identifying a new evidence-based model, DCF worked with providers to figure out the best way to get it started. In some cases, DCF supported the training of existing provider staff in a new model in order to “add tools to the providers’ toolkit.”

Resources Supporting Implementation and Sustainability

- The majority of DCF's active evidence-based programs are funded by state dollars, with some receiving additional support through Medicaid.
- DCF has reorganized its structure and staffing to support data and evaluation, performance management, and quality assurance. The agency also invested in workforce improvements, ensuring that everyone from leadership to frontline staff is operating in a data-informed, data-driven culture.
- Connecticut's emphasis on resourcing results, not services, has led to cost savings that are then used to fund more evidence-based programs. For example, DCF had overbuilt its congregate care services and relied heavily on them long beyond a child's or youth's treatment needs. With a greater understanding of the impact of congregate care on children and youth, DCF shifted funding to enhance the community-based service array through evidence-based and promising models. Over five fiscal years, the state has spent $80 million less on congregate care and reinvested many of those dollars into more effective services.

B-5. New Jersey

BACKGROUND/CONTEXT

The New Jersey Department of Children and Families (DCF) funds and administers a variety of services for children and families, including but not limited to child welfare, prevention, behavioral health and domestic violence services. DCF contracts with over 800 private providers implementing a range of evidence-based, evidence-informed and promising programming. Under the leadership of Commissioner Allison Blake, the Department prioritized the transition of the service array to research and evidence-supported service models in its 2014 strategic plan.

EVIDENCE-BASED PROGRAMS

Program Name	Program Type					Implementation Funding Source							
	Parenting Ed & Support	Behavioral Management	Mental Health	Dom Violence & Substance Abuse	Therapeutic Foster care & Perm Supports	State	City/ County	IV-E	IV-B	TANF	Medicaid	CBCAP	Federal Discretionary
Nurse–Family Partnership*	X					X				X			
Healthy Families*	X					X				X			
Home Instruction for Parents of Preschool Youngsters* (HIPPY)	X					X				X			
Trauma-Focused Cognitive Behavioral Therapy**		X	X			X							
Functional Family Therapy**		X	X	X		X							
Multisystemic Therapy**	X	X	X	X		X							

Note: DCF delivers additional models that do not meet the definition of evidence-based programs used in this brief.
**Home visiting models are also supported by federal Title V: Maternal and Child Health Services Block Grant dollars.*
***Detail on federal funding supporting TF-CBT, FFT and MST was not available at the time of publication of this brief.*

FINANCING EVIDENCE-BASED PROGRAMS

Key Lessons Learned

- Investing resources effectively requires more than simply selecting programs with the highest ratings and contracting for them. It is critical to do the following:

    1. Identify strategies or interventions that are supported by evidence, fit the needs of the community and are feasible to implement.

    2. Put the right structures and supports in place that are “in service to” the practice and help to carry out those practices faithfully.

    3. Develop effective collaboration through intentional, structured teaming processes, communication and data to keep everyone in sync and informed by feedback.

- Recognize that the service array will include services along a continuum of evidence. Focus on understanding and using the available data and evaluation research to inform practice. Begin by understanding the strength of the data supporting the existing service array, where there are opportunities to use programs supported by stronger evidence and/ or opportunities to build the evidence base.

- Resources to support the integration of evidence-based programs can often be made available by repurposing existing funds. Review existing contracts to ensure services are meeting the needs of families and are informed by or based on good evidence.

Resources Supporting Exploration and Installation

- DCF leadership prioritized a focus on results and identification of evidence-based/evidence informed models, and has allocated staff resources to support the exploration and installation of these types of services. The department’s current commissioner created the Office of Strategic Development (OSD), which is responsible for leading efforts to transition the child welfare service array to more evidence-based/evidence-informed programming. OSD also supports program development across the divisions in the department using implementation science principles. In addition, the OSD reviews and/or assists with the development of all department Requests for Proposals for community-based services, with the goal of ensuring a consistent approach across initiatives to match community needs with interventions that address those needs and with providers that have the capacity to implement the model. RFPs are also being reshaped to attend to and address the infrastructure needed to support high-quality implementation of the interventions. These efforts help to ensure that agency contracts

are focused on accountability for outcomes and support services with strong evidence of effectiveness.

- With support from the Annie E. Casey Foundation, the DCF partnered with the National Implementation Research Network (NIRN), a subset of New Jersey service providers and an expert advisory committee to develop a blueprint for how DCF and provider partners can approach the successful integration of evidence-based/evidence-informed models into the service array, using implementation science to guide the work. *The Implementation Science and Service Provider Informed Blueprint for the Integration of Evidence Based/Evidence Informed Practices into NJ's Child Welfare System* was completed in September 2016. The blueprint is geared toward developing a sustainable, consistent approach across initiatives and providers to: select interventions that meet community needs; attend to infrastructure to support high-quality implementation of the interventions; and shift systems to ensure these practices can be sustained over time. The Blueprint consists of recommendations for state child welfare agencies, systems partners and service providers/practitioners to support the effective integration of evidence-based/evidence-informed practices into a service array.

Resources Supporting Implementation and Sustainability

- Evidence-based programs currently being implemented are supported by state funds. Home visiting models are also supported by federal TANF dollars and Title V (the Maternal and Child Health Services Block Grant).
- DCF leaders are very focused on ensuring the infrastructure exists to support the effective implementation and sustainability of programs. This involves partnerships between child welfare, systems partners (e.g. model developers, intermediaries) and service providers to do the following:

    1. Assess strengths and gaps of infrastructure needed to support quality implementation of evidence-based/evidence-informed interventions (staffing, training and coaching capacity, availability/development of fidelity assessments, mechanisms for data collection, etc.).
    2. Based on the assessment, prioritize recommended changes that need to be made.
    3. Allocate resources (e.g. staff, funding, tools) to refine and/or develop prioritized infrastructure changes through teaming structures at the state, system and local levels to support providers in high quality implementation.

B-6. New York City

BACKGROUND/CONTEXT

The New York City Administration for Children's Services (ACS) is responsible for the administration of child welfare, juvenile justice and early care and education programs. New York State, which operates a county-administered child welfare system, has made long-standing and significant investments in preventive services. ACS contracts with private nonprofit organizations to support and stabilize families in crisis so children can remain safely at home though preventive services. Each year, roughly 22,000 families and almost 47,000 children receive in-home preventive family support services. The ACS preventive services budget was $256 million in 2017, a steady increase from $221 million in 2014. There has been strong mayoral support for preventive services, starting in the Bloomberg administration and continuing in the current DeBlasio administration, which is adding significant dollars to the preventive system.

Since 2013, ACS has dramatically increased the use of evidence-based programs in its child welfare preventive services contracts. The agency's focus on evidence-based programs derived in part from the leadership of the Bloomberg administration, which implemented reforms aimed at increasing accountability for outcomes among city-funded agencies. (Prior to the focus on child welfare preventive services, ACS successfully implemented evidence-based models within their juvenile justice services.) Currently, approximately 25 percent of the child welfare preventive services caseload (5,000 families annually) are served with an evidence-based program.

EVIDENCE-BASED PROGRAMS

Program Name	Documented Outcome Area					Implementation Funding Source								
	Parenting Ed & Prevention	Behavioral Management	Mental Health	Substance Abuse	Therapeutic Foster Care & Perm Supports	State	City/ County	IV-E	IV-B	TANF	Medicaid	CBCAP	Federal Discretionary	Private
SafeCare	X					X	X	X	X	X				
Functional Family Therapy (FFT)		X	X	X		X	X	X	X	X				
Brief Strategic Family Therapy (BSFT)		X	X			X	X	X	X	X				
Child–Parent Psychotherapy (CPP)			X			X	X	X	X	X				
Multisystemic Therapy for Child Abuse & Neglect (MST-CAN)	X		X			X	X	X	X	X				

Multisystemic Therapy for Substance Abuse (MST-SA)				X		X	X	X	X	X				
Family Connections	x					x	x	x	x	x				
Note: This chart includes two programs ACS categorizes as evidence-based that do not meet the definition used for this brief. MST-SA is rated effective by the Office of Justice Programs' CrimeSolutions.gov website that uses rigorous research to determine what works in criminal justice, juvenile justice and crime victim services. Family Connections is considered to have promising research evidence on CEBC. ACS delivers additional models that are evidence-informed or promising, including Functional Family Therapy – CW, Structural Family Therapy and Trauma Systems Therapy.														

FINANCING EVIDENCE-BASED PROGRAMS

Key Lessons Learned

- Supporting evidence-based programs is possible through existing child welfare service contracts. However, significant and ongoing commitment of leadership and administrative staff time is required to establish buy-in; shepherd the selection and implementation of programs; align agency policy and program requirements; establish internal structures, processes and tools to support integration of the programs within agency practice; and continuously gather feedback from providers and work collaboratively to address challenges.

- Engaging providers as partners is critical to successfully converting contracts to evidence-based programs. This includes early involvement with opportunities for providers to give input on the selection of evidence-based programs and make choices about which models they want to implement based on their capacity. Working together, agencies and providers should develop an understanding of the costs of evidence-based programs and adjust rates within contracts accordingly, establish ongoing processes for dialogue about implementation and express a willingness to address barriers posed by existing agency policy or practice norms.

- Agencies should consider the high rate of staff turnover in the child welfare field and calculate the ongoing costs of training new staff on an evidence-based program. High turnover can be costly and create disruptions in the availability of services. Training and certifying local trainers who can be available to train new staff can be more cost efficient than relying on trainers from national office of the program developer, depending on the scale of implementation.

Resources Supporting Exploration and Installation

- Casey Family Programs (CFP), a national operating foundation that focuses on the safety and success of children, families and communities, supported technical assistance from the National Implementation Research Network (NIRN) to help ACS administrators identify appropriate evidence-based programs and engage staff and providers in the process of

converting contracts to include evidence-based models. (For more information on the collaboration between CFP and NIRN: https://www.casey.org/media/evidence-based-child-welfare-nyc.pdf)

- ACS established a cross-divisional leadership team that served as a vehicle for gathering input from across the agency as they developed the plan for implementing evidence-based programs. Additionally, specific task teams focused on capacity building, policy and practice alignment and evaluation and monitoring.
- ACS pooled resources from expiring prevention contracts and used the funds to fill gaps in preventive services with evidence-based programs, particularly for teens. The city also allocated new resources to support implementation of evidence-based models.
- ACS issued an expression of interest (EOI) to existing providers, offering them the option to make a no-cost conversion from their existing prevention services to one of the evidence-based models. Before issuing the EOI, ACS gathered input from providers on the process and presented opportunities for them to learn about the selected evidence-based models. ACS also issued an RFP for new contracts to specifically serve families with teens.

Resources Supporting Implementation and Sustainability

- The main sources of support for implementation of the evidence-based programs are the federal, state and city resources that have historically funded prevention services. Twenty-two providers agreed to implement evidence-based models, either through a conversion of their existing contract or through a new procurement. While the higher cost of evidence-based models has sometimes meant the provider had to serve fewer families at a given time, the duration of the programs is shorter than traditional prevention services, so the total number of families served has increased.
- The state and city funds allocated to prevention services have steadily increased in recent years, enabling ACS to expand contracts and create additional administrative support positions, including program development managers who oversee implementation of evidence-based models and liaise between ACS, the evidence-based model developers and the ACS providers.
- ACS delegates case management to its contracted provider agencies. ACS has integrated the funding and implementation of the evidence-based models into the agency's core case management function. ACS administrators worked diligently with program developers and providers to align the evidence-based program requirements with case management requirements. For each program, they created logic models to articulate the alignment and help providers clearly understand what is required of them to implement the programs with fidelity while also fulfilling case management functions.

- ACS has developed training and information supports to ensure that investigating workers understand the evidence-based programs and can make appropriate referrals. Training in how to match a family with the evidence-based model that best fits is being integrated into the agency's Workforce Institute, and ACS is now launching e-learning modules that help workers learn about making the best match between a family and an evidence-based practice. ACS developed a desk guide for staff containing brief overviews of the evidence-based programs, and a companion Frequently Asked Questions booklet. A web-based decision-making tool provides workers with a list of appropriate models based on information entered about the needs of the family.

B-7. North Carolina

BACKGROUND/CONTEXT

North Carolina operates a state-supervised, county-administered child welfare system. The Department of Health and Human Services, Division of Social Services (DSS) is responsible for ensuring county child-welfare agencies comply with federal and state laws and policies, and also supports training, evaluation and quality improvement. DSS is the lead agency for key federal Community-Based Child Abuse Prevention (CBCAP) funds, as well as traditional child-welfare funding streams. The agency administers the North Carolina Children's Trust Fund (funded by license plate fees and marriage license fees), Title IV-B and Title IV-E.

Over the years, DSS leaders have worked closely with private and public sector partners to identify evidence-based prevention programs and support quality implementation of those programs. The agency also has a partnership with the North Carolina Child Treatment Program to help ensure that children receive evidence-based trauma treatment.

EVIDENCE-BASED PROGRAMS

Program Name	Demonstrated Outcome Areas					Implementation Funding Source								
	Parenting Ed & Prevention	Behavioral Management	Mental Health	Substance Use	Therapeutic Foster Care & Perm Supports	State	City/ County	IV-E	IV-B	TANF	Medicaid	CBCAP	Federal Discretionary	Private
Adolescent Community Reinforcement Approach (A-CRA)				X		X					X			
Attachment and Biobehavioral Catch-up (ABC)	X	X	X			X						X	X	
Brief Strategic Family Therapy		X	X			X					X			
Child First	X	X	X			X					X			
Child–Parent Psychotherapy (CPP)		X	X			X					X			
Cognitive Behavioral Therapy (CBT)			X			X					X			
Eye Movement Desensitization and Reprocessing			X			X					X			
Homebuilders	X				X	X			X					
Incredible Years	X	X	X			X			X			X		
Multi-Systemic Therapy (MST)	X	X	X	X		X					X			
Parent–Child Interaction Therapy (PCIT)	X	X	X			X					X		X	X
SafeCare	X					X			X			X		
Seeking Safety			X	X		X					X			
Strengthening Families	X	X		X		X			X			X		
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)		X	X			X					X			
Triple P	X	X	X			X			X			X		

Note: North Carolina delivers additional models that do not meet the definition of evidence-based programs used in this brief, but that staff identified as evidence-informed or promising, including Circle of Parents, Seven Challenges, Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS), Dialectical Behavioral Therapy, Assertive Community Treatment, High Fidelity Wraparound and Family Centered Treatment™.

FINANCING EVIDENCE-BASED PROGRAMS

Key Lessons Learned

- Child welfare agency leaders must be committed to evidence-based programs for the long term. It takes time to implement models with fidelity, and even longer to see changes in outcomes.
- Private sector partners, including foundation funders, universities and intermediary agencies, can bring critical resources and capacity to the work of identifying appropriate evidence-based programs and supporting quality implementation.
- Investments in supports for training, coaching and evaluation are essential to ensure successful implementation.

Resources Supporting Exploration and Installation

- In 2005, the North Carolina Institute of Medicine and Prevent Child Abuse North Carolina convened a taskforce on child abuse prevention, which brought together key public and private sector stakeholders to review data and develop recommendations for reducing the incidence of child maltreatment in the state. In response to a recommendation to fund evidence-based interventions, an alliance of funders formed to identify evidence-based programs on which they would focus as a group. Participation in these efforts led DSS use community-based prevention dollars to fund the Incredible Years, Strengthening Families and Circle of Parents programs, and most recently, to partner with the Division of Public Health to support the Triple P program.
- Once the programs were identified, DSS coordinated resources from CBCAP, Title IV-B and the Children's Trust Fund to support one request for application (RFA) for evidence-based and informed prevention programs (Incredible Years, Strengthening Families and Circle of Parents).

Resources Supporting Implementation and Sustainability

- The ongoing implementation of evidence-based prevention programs is funded with CBCAP, IV-B and Children's Trust Fund dollars.
- Through funding from DSS and The Duke Endowment, Prevent Child Abuse North Carolina offers ongoing training, implementation support and coaching to sites implementing Incredible Years, Strengthening Families and Circle of Parents across the state.

- DSS's focus on partnerships has enabled the agency to leverage and build on existing state resources. The North Carolina Public Health Division supports the implementation of Triple P in 36 counties statewide. DSS recently allocated $1.5 million in state funds for implementation support and referral mechanisms to help ensure that Triple P is part of the child welfare service array in counties where it is being implemented.
- In 2011, DSS received a five-year federal Children's Bureau grant focused on integrating trauma-informed practices in child-protective service delivery. The agency used grant resources to build the capacity of the North Carolina Child Treatment Program (NC CTP), which trains clinicians throughout the state to implement therapeutic evidence-based programs, such as Parent-Child Interaction Therapy, Trauma-Focused Cognitive Behavioral Therapy, and Child-Parent Psychotherapy. DSS no longer directly funds NC CTP; however, DSS workers refer clients to clinicians on the NC CTP roster, indicating they have high-quality training in evidence-based therapeutic models, and those services are supported with state and Medicaid funding.
- Multiple partners, including The Duke Endowment and the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services, have funded NC CTP in addition to DSS.

B-8. Ohio

BACKGROUND/CONTEXT

Ohio Children's Trust Fund (OCTF) is a quasi-governmental agency with a mission to prevent child abuse and neglect. Housed within the state child welfare agency, OCTF's goal is to prevent entry into the child welfare system. OCTF funds primary and secondary prevention strategies conducted at the local and state levels.

Founded in 1984, OCTF is the only dedicated public funding source for child abuse and neglect prevention throughout Ohio. The appointed board of directors that governs OCTF includes public agency directors, legislators and subject matter experts. OCTF receives about $1 million annually from Ohio's federal Community-Based Child Abuse Prevention state grant. The rest of OCTF's funding comes from state birth and death certificate fees, divorce and dissolution fees, as well as individual, foundation and corporate giving.

Until recent years, every county-administered child welfare agency in Ohio received a preset allocation of prevention funding, with few accountability requirements attached. In 2010, the Kasich administration brought about an increased focus on ensuring outcomes across all government services. As a result, OCTF began to emphasize the funding of evidence-based prevention programs. Eventually, with the support of the governor and legislators, the state statute was changed to fundamentally alter how OCTF allocated its prevention funding. OCTF funding is now granted through a competitive regional process, and tied to the implementation of evidence-based or evidence-informed practices.

EVIDENCE-BASED PROGRAMS

Program Name	Demonstrated Outcome Area					Implementation Funding Source								
	Parenting Ed & Prevention	Behavioral Management	Mental Health	Substance Use	Therapeutic Foster Care & Perm Supports	State	City/County	IV-E	IV-B	TANF	Medicaid	CBCAP	Federal Discretionary	Private
Incredible Years	X	X	X			X						X		X
Strengthening Families	X	X		X		X						X		X
Triple P	X	X	X			X						X		X

Note: Through the Ohio Trust Fund, Ohio county agencies and nonprofit organizations deliver additional models that do not meet the definition of evidence-based programs used in this brief, but that staff identified as evidence-informed or promising. These programs include Active Parenting Now, Nurturing Parenting and FAST.

FINANCING EVIDENCE-BASED PROGRAMS

Key Lessons Learned

- Evidence-based programs can be funded with existing public dollars that are being spent on programs that do not produce results. This shift in public spending can often result in political backlash, so strong commitment from state leadership is critical. Framing the case around increased accountability helps political leaders withstand pressure and make the necessary changes.
- It takes time to change the culture of an organization, and a commitment to using evidence-based programs is a culture change. Take smaller steps, such as using existing resources to better assess needs and identify gaps. Begin to require outcome-based reporting. Build capacity at the local and state levels to select and plan for implementing evidence-based programs. As the culture shifts, there will be more openness to fundamentally changing how funding decisions are made.

Resources Supporting Exploration and Installation

- OCTF provided technical assistance and data analysis to help counties shift to an outcome-based approach, including developing a standardized reporting template.
- OCTF staff worked directly with county prevention specialists to assess their local needs and find an evidence-based program to match them. Despite their best efforts, there were not always evidence-based programs that were the right fit. At times, OCTF asked the program developer if a modification could be made, e.g., shifting a treatment from group-based to home-based. Modifications were not always possible, but in some cases, OCTF was able to work with the developer to test a modification or a new population.
- For evidence-based programs that experienced a lot of uptake, such as Triple P and Incredible Years, OCTF used state dollars to support cross-county trainings. This lowered the burden at the local level, while also building capacity to sustain training for the programs across the state.

Resources Supporting Implementation and Sustainability

- Starting in 2016, OCTF changed how it funds prevention programs throughout the state. Using the same resource streams, OCTF now allocates dollars through a regional funding model. Eight regions are led by Regional Prevention Councils. Each region has a university partner that can provide training and technical assistance and support research and evaluation. Regional prevention coordinators, working in partnership with county prevention specialists, direct the councils. Together, the regional prevention coordinator and county prevention specialists conduct a comprehensive needs assessment and create a regional prevention plan. The plan must demonstrate that they will use evidence-based or promising programs. After

receiving OCTF board approval of the regional prevention plan, prevention coordinators contract with service providers to serve families in their regions and ensure that all progress is measured and reported.

- The outcome-based data training and support have built the capacity of local agencies to attract other funders. Ohio counties that have embraced this approach are now able to use their outcomes data to engage with United Ways and other local foundations and solicit additional resources.

B-9. Washington State

BACKGROUND/CONTEXT

The leadership of the Washington State Department of Social and Health Services, Children's Administration (CA), began to prioritize the implementation of evidence-based programs, including fidelity monitoring, in 2005. Since that time, within a state policymaking context increasingly focused on the use of evidence-based models, CA has been committed to expanding the number and scope of evidence- and research-based programs. In 2012, the state passed a bill that required human service agencies to develop a baseline analysis of their use of evidence-based programs and develop targets for increasing that use over time. This legislation affirmed the direction the CA had been taking, and has contributed to the available data the agency can collect to inform the implementation of evidence-based programs.

EVIDENCE-BASED PROGRAMS

Program Name	Demonstrated Outcome Area					Implementation Funding Source								
	Parenting Ed & Prevention	Behavioral Management	Mental Health	Substance Use	Therapeutic Foster Care & Perm Supports	State	City/ County	IV-E	IV-B	TANF	Medicaid	CBCAP	Federal Discretionary	Private
Functional Family Therapy (FFT)		X	X	X		X								
Homebuilders	X				X	X			X					
Incredible Years	X	X	X			X								
Parent–Child Interaction Therapy (PCIT)	X	X	X			X			X		X			
SafeCare	X					X								
Triple P	X	X	X			X								
Note: Children's Administration delivers additional models that do not meet the definition of evidence-based programs used in this brief, but that staff identified as evidence-informed or promising, such as Promoting First Relationships.														

FINANCING EVIDENCE-BASED PROGRAMS

Key Lessons Learned

- Evidence-based programs can be supported with the dollars in existing service contracts. The transition requires a careful analysis of what is needed to implement the evidence-based

program with fidelity. Provider rates must be adjusted to reflect the real staff time required for engagement, fidelity monitoring and casework, as well as clinical service.

- When the decision was made to transition to more expensive evidence-based services, Washington state's child welfare leadership was willing to risk being able to serve fewer families; however, this risk has not been realized to date. This is likely due to shorter lengths of service in evidence-based programs and fewer cases of "back-to-back" services, the practice of a child or family repeating the same or being referred to a similar service when the first service has not been successfully completed.
- There are no appropriate evidence-based programs to address all of the functions of child welfare agencies and the needs of families. To make effective investments, careful consideration must be given to which evidence-based programs can meet the needs of families on the agency's caseload, and which evidence-based programs are in line with the agency's focus and current priorities.
- Turnover is expensive when evidence-based programs require significant investments in initial training of staff. Agencies should consider the staff retention rates of providers before contracting with them to deliver evidence-based programs.

Resources Supporting Exploration and Installation

- CA has put in place service array managers at both state and regional levels. These managers are responsible for identifying gaps in the service array and overseeing the implementation of new programs. They gather input from workers and providers on potential new evidence-based programs and meet with each other to decide what types evidence-based programs are needed for what populations.
- CA has directly funded training for staff of provider agencies in the evidence-based programs selected for implementation. The high level of turnover among staff has led CA to prioritize training the staff of providers with better retention rates.
- As part of the installation process, CA focused on gatekeeping within each region to ensure that referrals to evidence-based programs were being made when appropriate. Regional service array managers had to approve referrals to non-evidence-based programs. Additionally, CA staff adapted the agency's statewide child welfare information system to request an explanation, whenever a worker made a referral to a non-evidence-based program, for why an evidence-based program was not being used. This intentional focus helped to change the culture of the agency and ensure take-up of new evidence-based programs.

Resources Supporting Implementation and Sustainability

- CA increased its rates to cover the higher cost of evidence-based programs. CA staff has done careful analysis of the time required for fidelity monitoring and quality assurance activities for each program, and has built in reimbursement for those functions. Recognizing that many of the basic needs of families are not addressed through the evidence-based programs, CA staff also included additional case management hours in its rates so that providers can help with issues such as housing and employment.
- The main funding sources supporting implementation of the evidence-based programs are state funds. A small amount of IV-B funding is also used. These dollars, approximately $12 million in 2016, were historically in contracts for family preservation services.
- The total amount of funds supporting in-home services has increased over the last six years, as has the proportion of those funds supporting evidence-based programs. In 2011, approximately 25 percent of family preservation funds were spent on evidence-based programs, with 75 percent spent on services that were not evidence based. By 2017, approximately 60 – 70 percent of family preservation spending was on evidence-based programs, with 30 – 40 percent going to non-evidence-based programs.
- CA has developed training and information supports to ensure that workers responsible for making referrals understand the various evidence-based programs, and can direct families to appropriate providers. A web-based decision-making tool was created to provide workers with a list of evidence-based programs based on information entered about the needs of the family, and a guide was also developed containing brief overviews of each of the programs.